

ARTICLE 3. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Rule 1. General Provisions

760 IAC 3-1-1 Applicability and scope

Authority: IC 27-8-13-10

Affected: IC 27-8-13-1

Sec. 1. (a) Except as otherwise specifically provided in 760 IAC 3-5, 760 IAC 3-11, 760 IAC 3-14, and 760 IAC 3-19, this article shall apply to the following:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation.

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(b) This article shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations. (*Department of Insurance; 760 IAC 3-1-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3412; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 2. Definitions

760 IAC 3-2-1 Applicability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. The definitions in this rule apply throughout this article. (*Department of Insurance; 760 IAC 3-2-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-2 "Applicant" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2. "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; or

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

(*Department of Insurance; 760 IAC 3-2-2; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-2.5 "Bankruptcy" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2.5. As used in this rule, "bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Indiana. (*Department of Insurance; 760 IAC 3-2-2.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-3 "Certificate" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 3. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement

policy. (*Department of Insurance; 760 IAC 3-2-3; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-4 “Certificate form” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4. “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer. (*Department of Insurance; 760 IAC 3-2-4; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-4.5 “Continuous period of creditable coverage” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4.5. As used in this rule, “continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days. (*Department of Insurance; 760 IAC 3-2-4.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-2-4.6 “Creditable coverage” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4.6. (a) As used in this rule, “creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

- (1) A group health plan.
 - (2) Health insurance coverage.
 - (3) Part A or Part B of Title XVIII of the Social Security Act (Medicare).
 - (4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928.
 - (5) Chapter 55 of Title 10, United States Code (CHAMPUS).
 - (6) A medical care program of the Indian Health Service or of a tribal organization.
 - (7) A state health benefits risk pool.
 - (8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program).
 - (9) A public health plan as defined in federal regulation.
 - (10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- (b) The term shall not include one (1) or more, or any combination of, the following:
- (1) Coverage only for accident or disability income insurance, or any combination thereof.
 - (2) Coverage issued as a supplement to liability insurance.
 - (3) Liability insurance, including general liability insurance and automobile liability insurance.
 - (4) Workers’ compensation or similar insurance.
 - (5) Automobile medical payment insurance.
 - (6) Credit-only insurance.
 - (7) Coverage for on-site medical clinics.
 - (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (c) The term shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
- (1) Limited scope dental or vision benefits.
 - (2) Benefits for long term care, nursing home care, home health care, community-based care, or any combination thereof.

- (3) Such other similar, limited benefits as are specified in federal regulations.
- (d) The term shall not include the following benefits if offered as independent, noncoordinated benefits:
 - (1) Coverage only for a specified disease or illness.
 - (2) Hospital indemnity or other fixed indemnity insurance.
- (e) The term shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:
 - (1) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.
 - (2) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code.
 - (3) Similar supplemental coverage provided to coverage under a group health plan.

(Department of Insurance; 760 IAC 3-2-4.6; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 3-2-4.7 “Employee welfare benefit plan” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4.7. As used in this rule, “employee welfare benefit plan” means a plan, fund, or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act). *(Department of Insurance; 760 IAC 3-2-4.7; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-4.8 “Insolvency” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4.8. As used in this rule, “insolvency” means when an issuer, licensed to transact the business of insurance in Indiana, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile. *(Department of Insurance; 760 IAC 3-2-4.8; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-5 “Issuer” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 5. “Issuer” means insurance companies, fraternal benefit societies, prepaid health care delivery plans, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates. *(Department of Insurance; 760 IAC 3-2-5; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-6 “Medicare” or “Medicare program” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 6. “Medicare” or “Medicare program” means the “Health Insurance for the Aged Act”, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. *(Department of Insurance; 760 IAC 3-2-6; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-6.1 “Medicare+Choice organization” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 6.1. As used in this rule, “Medicare+Choice organization” has the meaning as set forth in 42 U.S.C. 1395w-28.

(Department of Insurance; 760 IAC 3-2-6.1; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 3-2-6.2 “Medicare+Choice plan” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 6.2. As used in this rule, “Medicare+Choice plan” has the meaning as set forth in 42 U.S.C. 1395w-28. *(Department of Insurance; 760 IAC 3-2-6.2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-7 “Medicare supplement policy” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 7. “Medicare supplement policy” means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. § 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. *(Department of Insurance; 760 IAC 3-2-7; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3413; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-8 “Policy form” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 8. “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 3-2-8; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-9 “Secretary” defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 9. As used in this rule, “Secretary” means the Secretary of the United States Department of Health and Human Services. *(Department of Insurance; 760 IAC 3-2-9; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 3. Policy Definitions and Terms

760 IAC 3-3-1 Policy definitions and terms

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this article.

(b) “Accident”, “accidental injury”, or “accidental means” shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization and as follows:

(1) The definition shall not be more restrictive than the following: “Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person, which is the direct result of an accident, independent of disease or

bodily infirmity or any other cause, and occurs while insurance coverage is in force.”.

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(c) “Benefit period” or “Medicare benefit period” shall not be defined more restrictively than as defined in the Medicare program.

(d) “Convalescent nursing home”, “extended care facility”, or “skilled nursing facility” shall not be defined more restrictively than as defined in the Medicare program.

(e) “Health care expenses” means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include the following:

- (1) Home office and overhead costs.
- (2) Advertising costs.
- (3) Commissions and other acquisition costs.
- (4) Taxes.
- (5) Capital costs.
- (6) Administrative costs.
- (7) Claims processing costs.

(f) “Hospital” may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(g) “Medicare” shall be defined in the policy and certificate. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended”, or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof”, or words of similar import.

(h) “Medicare eligible expenses” shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(i) “Physician” shall not be defined more restrictively than as defined by Medicare.

(j) “Sickness” shall not be defined to be more restrictive than the following:

(1) “Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.”.

(2) The definition in subdivision (1) may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(Department of Insurance; 760 IAC 3-3-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 4. Policy Provisions

760 IAC 3-4-1 Policy provisions

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) Except for permitted preexisting condition clauses as described in 760 IAC 3-5-1(b)(1) and 760 IAC 3-6-1(b), no policy or certificate shall be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare. *(Department of Insurance; 760 IAC 3-4-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2565; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 5. Minimum Benefit Standards

760 IAC 3-5-1 Minimum benefit standards for policies or certificates issued for delivery prior to January 1, 1992

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate prior to January 1, 1992, unless it meets or exceeds the minimum standards in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) The following standards apply to Medicare supplement policies and certificates issued prior to January 1, 1992, and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(A) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(B) be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5) Except as authorized by the commissioner of the department of insurance in this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(6) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subdivision (8), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(A) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy.

(B) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 760 IAC 3-6-1(c).

(7) If membership in a group is terminated, the issuer shall:

(A) offer the certificate holder such conversion opportunities as are described in subdivision (6); or

(B) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(8) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(9) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

(c) Minimum benefit standards are as follows:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (one hundred dollars (\$100)).

(d) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount. (*Department of Insurance; 760 IAC 3-5-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2565; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3413; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 6. Benefit Standards

760 IAC 3-6-1 Benefit standards for policies or certificates issued or delivered on or after December 31, 1991

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with benefit standards in this section.

(b) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable and shall meet the following requirements:

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (E), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for such benefits as otherwise meets the requirements of this subsection.

(D) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificate holder the conversion opportunity described in clause (C); or

(ii) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group

policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7) Each Medicare supplement policy shall do the following:

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

(B) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(C) Reinstitution of such coverages:

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(c) Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof. The standards for basic core benefits common to all benefit plans are as follows:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(d) The additional benefits shall be included in Medicare supplement benefit Plans B through J only as provided by 760 IAC

3-7. The standards for additional benefits are as follows:

(1) Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

- (3) Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
 - (4) Eighty percent (80%) of the Medicare Part B excess charges, coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
 - (5) One hundred percent (100%) of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
 - (6) Basic outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.
 - (7) Extended outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.
 - (8) Medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
 - (9) Preventive medical care benefit, coverage for the following preventive health services:
 - (A) An annual clinical preventive medical history and physical examination that may include tests and services from clause (B) and patient education to address preventive health care measures.
 - (B) Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
 - (i) Fecal occult blood test and/or digital rectal examination.
 - (ii) Mammogram.
 - (iii) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.
 - (iv) Pure tone (air only) hearing screening test, administered or ordered by a physician.
 - (v) Serum cholesterol screening (every five (5) years).
 - (vi) Thyroid function test.
 - (vii) Diabetes screening.
 - (C) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster (every ten (10) years).
 - (D) Any other tests or preventive measures determined appropriate by the attending physician.
- Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.
- (10) At-home recovery benefit, coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery, including the following requirements:
 - (A) For purposes of this subdivision, the following definitions shall apply:
 - (i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
 - (ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
 - (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would

qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one (1) visit.

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(AA) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(BB) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.

(CC) One thousand six hundred dollars (\$1,600) per calendar year.

(DD) Seven (7) visits in any one (1) week.

(EE) Care furnished on a visiting basis in the insured's home.

(FF) Services provided by a care provider as defined in clause (A)(ii).

(GG) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(HH) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(iv) Coverage is excluded for the following:

(AA) Home care visits paid for by Medicare or other government programs.

(BB) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(11) An issuer may, with the prior approval of the commissioner of the department of insurance, offer a policy or certificate with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

(Department of Insurance; 760 IAC 3-6-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2566; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3414; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 7. Standard Medicare Supplement Benefit Plans

760 IAC 3-7-1 Standard Medicare supplement benefit plans

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as defined in 760 IAC 3-6-1(c).

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 760 IAC 3-6-1(d)(11) and 760 IAC 3-8.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit Plans A through J listed in this section and conform to the definitions in 760 IAC 3-2 and 760 IAC 3-3. Each benefit shall be structured in accordance with the format provided in 760 IAC 3-6-1(c) through 760 IAC 3-6-1(d) and list the benefits in the order shown in subsection (e). As used in this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) Makeup of benefit plans shall be as follows:

(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans as defined in 760 IAC 3-6-1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus the Medicare Part A deductible as defined in 760 IAC 3-6-1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) Medicare Part B deductible; and
- (D) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3) and 760 IAC 3-6-1(d)(8), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) medically necessary emergency care in a foreign country; and
- (D) at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.

(5) Standardized Medicare supplement benefit Plan E shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) medically necessary emergency care in a foreign country; and
- (D) preventive medical care;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2) and 760 IAC 3-6-1(d)(8) through 760 IAC 3-6-1(d)(9), respectively.

(6) Standardized Medicare supplement benefit Plan F shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges; and
- (E) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(8), respectively.

(7) Standardized Medicare supplement benefit high deductible Plan F shall include one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) Medicare Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges; and
- (E) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2) and 760 IAC 3-6-1(d)(8) through 760 IAC 3-6-1(d)(9), respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1999 and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(8) Standardized Medicare supplement benefit Plan G shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) eighty percent (80%) of the Medicare Part B excess charges;

- (D) medically necessary emergency care in a foreign country; and
 - (E) at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(4), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.
- (9) Standardized Medicare supplement benefit Plan H shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) basic prescription drug benefit; and
 - (D) medically necessary emergency care in a foreign country;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(6), and 760 IAC 3-6-1(d)(8), respectively.
- (10) Standardized Medicare supplement benefit Plan I shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) one hundred percent (100%) of the Medicare Part B excess charges;
 - (D) basic prescription drug benefit;
 - (E) medically necessary emergency care in a foreign country; and
 - (F) at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 03-6-1(d)(5) [*sic.*, 760 IAC 3-6-1(d)(5)] through 760 IAC 3-6-1(d)(6), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.
- (11) Standardized Medicare supplement benefit Plan J shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) Medicare Part B deductible;
 - (D) one hundred percent (100%) of the Medicare Part B excess charges;
 - (E) extended prescription drug benefit;
 - (F) medically necessary emergency care in a foreign country;
 - (G) preventive medical care; and
 - (H) at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively.
- (12) Standardized Medicare supplement benefit high deductible Plan J shall consist of one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan J deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) Medicare Part B deductible;
 - (D) one hundred percent (100%) of the Medicare Part B excess charges;
 - (E) extended outpatient prescription drug benefit;
 - (F) medically necessary emergency care in a foreign country;
 - (G) preventive medical care benefit; and
 - (H) at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively. The annual high deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy and shall be in addition to any other specific benefit deductibles. The annual high deductible shall be one thousand five hundred dollars (\$1,500) for 1999 and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to

the nearest multiple of ten dollars (\$10).

(Department of Insurance; 760 IAC 3-7-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2569; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 8. Medicare Select Policies and Certificates

760 IAC 3-8-1 Medicare select policies and certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) This section shall apply to Medicare select policies and certificates as defined in this section.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(c) The following definitions apply throughout this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers.

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

(4) "Medicare select policy" or "Medicare select certificate" means, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner of the department of insurance within which an issuer is authorized to offer a Medicare select policy.

(d) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, under this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner of the department of insurance finds that the issuer has satisfied all of the requirements of this article.

(e) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner of the department of insurance.

(f) A Medicare select issuer shall file a proposed plan of operation with the commissioner of the department of insurance in a format prescribed by the commissioner of the department of insurance. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of the following:

(A) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This clause

shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate.

- (2) A statement or map providing a clear description of the service area.
- (3) A description of the grievance procedure to be utilized.
- (4) A description of the quality assurance program, including the following:
 - (A) The formal organizational structure.
 - (B) The written criteria for selection, retention, and removal of network providers.
 - (C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
- (5) A list and description, by specialty, of the network providers.
- (6) Copies of the written information proposed to be used by the issuer to comply with subsection (k).
- (7) Any other information requested by the commissioner of the department of insurance.

(g) A Medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner of the department of insurance prior to implementing such changes. Such changes shall be considered approved by the commissioner of the department of insurance after thirty (30) days unless specifically disapproved.

(h) An updated list of network providers shall be filed with the commissioner of the department of insurance at least quarterly.

(i) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers

if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

(j) A Medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(k) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with the following:

(A) Other Medicare supplement policies or certificates offered by the issuer.

(B) Other Medicare select policies or certificates.

(2) A description, including address, phone number, and hours of operation of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare select issuer's quality assurance program and grievance procedure.

(l) Prior to the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (k) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(m) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures as follows:

(1) The grievance procedure shall be described in the policies and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31 to the commissioner of the department of insurance regarding its

grievance procedure. The report shall be in a format prescribed by the commissioner of the department of insurance and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(n) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(o) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that:

- (1) has comparable or lesser benefits; and
- (2) does not contain a restricted network provision.

The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six (6) months.

(p) For purposes of subsection (o), a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced.

As used in this subsection, "significant benefit" means coverage for:

- (1) the Medicare Part A deductible;
- (2) prescription drugs;
- (3) at-home recovery services; or
- (4) Part B excess charges.

(q) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment and as follows:

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced. As used in this subdivision, "significant benefit" means coverage for:

- (A) the Medicare Part A deductible;
- (B) prescription drugs;
- (C) at-home recovery services; or
- (D) Part B excess charges.

(r) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program. (*Department of Insurance; 760 IAC 3-8-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2570; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3417; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 9. Open Enrollment

760 IAC 3-9-1 Open enrollment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(c) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the sum of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in this section and 760 IAC 3-9-1, subsection (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. (*Department of Insurance; 760 IAC 3-9-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1975; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

760 IAC 3-9-2 Guaranteed issue for eligible persons

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2. (a) As used in this section, “eligible person” means an individual described in any of the following:

(1) An individual enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates or the plan implements a material reduction of supplemental health benefits to the individual, or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

(2) An individual enrolled with a Medicare+Choice organization under a Medicare+Choice plan and any of the following circumstances apply:

(A) The organization’s or plan’s certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(B) The individual is no longer eligible to elect the plan because of a change in the individual’s place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual’s enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) the organization, or agent or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in marketing the plan to the individual. or

(D) The individual meets such other exceptional conditions as the Secretary may provide.

(3) An individual enrolled in one (1) of the following:

(A) an eligible organization under a contract under Section 1876 (Medicare risk or cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy;

and the enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under subsection (a)(2) of this section [*subdivision (2)*].

(4) An individual enrolled under a Medicare supplement policy and the enrollment ceases due to one (1) of the following:

(A) Insolvency of the issuer, bankruptcy of the organization, or other involuntary termination of coverage or enrollment under the policy.

(B) The issuer of the policy substantially violated a material provision of the policy. or

- (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
- (5) An individual enrolled under a Medicare supplement policy who:
- (A) terminates enrollment and subsequently enrolls with:
 - (i) any Medicare+Choice organization under Medicare+Choice plans;
 - (ii) any eligible organization under a contract under Section 1876 (Medicare risk or cost) or any similar organization operating under demonstration project authority;
 - (iii) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
 - (iv) a Medicare Select policy; and
 - (B) during the first twelve (12) months after the initial termination of enrollment from the Medicare supplement policy under clause (A), the individual:
 - (i) terminates any subsequent enrollments in plans or organizations described in clause (A)(i), (A)(ii), (A)(iii), or (A)(iv); and
 - (ii) applies to enroll with a Medicare supplement policy.
- (6) An individual who, upon first enrolling in Medicare Part B, enrolls in any Medicare+Choice plans and disenrolls from the plans not later than twelve (12) months after the effective date of the individual's first enrollment.
- (b) With respect to eligible persons who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (a) and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy, an issuer shall not:
- (1) deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer;
 - (2) discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and
 - (3) impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
- (c) An eligible person as defined by subsection (a)(1), (a)(2), (a)(3), or (a)(4) is guaranteed issuance of a standardized Medicare supplement benefit Plan A, Plan B, Plan C, or Plan F offered by any issuer.
- (d) An eligible person as defined by subsection (a)(5) is guaranteed issuance of the same standardized Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (c).
- (e) An eligible person as defined by subsection (a)(6) is guaranteed issuance of any standardized Medicare supplement policy offered by any issuer.
- (f) At the time of an event described in subsection (a), either the organization that terminates the contract or agreement, the employee welfare benefit plan, the issuer of the policy, or the administrator of the plan being terminated shall notify the individual of his or her rights under this section.
- (g) At the time of an event described in subsection (a) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, either the organization that offers the contract or agreement, the issuer offering the policy, or the administrator of the plan shall notify the individual of his or her rights under this section. Such notice shall be communicated to the individual within ten (10) working days of the issuer receiving notification of disenrollment. (*Department of Insurance; 760 IAC 3-9-2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1976; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 10. Standards for Claims Payment

760 IAC 3-10-1 Claims payment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by doing the following:

- (1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis

of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent.

(5) Paying user fees for claim notices that are transmitted electronically or otherwise.

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements set forth in subsection (a) shall be certified on the Medicare supplement insurance experience reporting form. (*Department of Insurance; 760 IAC 3-10-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 11. Loss Ratio Standards and Refund or Credit of Premium

760 IAC 3-11-1 Loss ratio standards and refund or credit of premium

Authority: IC 27-8-13-10; IC 27-8-13-12

Affected: IC 27-8-13-1

Sec. 1. (a) Loss ratio standards are as follows:

(1) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(A) at least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(B) at least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For policies issued any time prior to January 1, 1992, expected claims in relation to premiums shall meet the following:

(A) The originally filed anticipated loss ratio when combined with the actual experience since inception.

(B) The appropriate loss ratio requirement from subdivision (1) when combined with actual experience beginning with April 1, 1996, to date.

(C) The appropriate loss ratio requirements from subdivision (1) over the entire future period for which the rates are computed to provide coverage.

(D) In meeting the tests in clauses (A) through (C) and for purposes of attaining credibility, an issuer may combine experience under policy forms that provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience except with the approval of the commissioner.

(b) Refund or credit calculation is as follows:

(1) An issuer shall collect and file with the commissioner of the department of insurance by May 31 of each year the data contained in the applicable reporting form contained in this section for each type in a standard Medicare supplement benefit plan.

(2) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For purposes of this section, the issuer of policies or certificates issued prior to January 1, 1992, shall make the refund

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 1, 1996. The first such report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates issued before or after the effective date of this article in this state shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three (3) years.

(d) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner of the department of insurance, in accordance with the applicable filing procedures of this state, the following:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment, which would modify the loss ratio experience under the policy other than the adjustments described in this subdivision, shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner of the department of insurance, the commissioner of the department of insurance may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(4) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(e) The commissioner of the department of insurance may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this article if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner of the department of insurance.

(f) The following forms shall be used for the calculations and reporting requirements of this rule:

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE¹ _____

SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____

NAIC Company Code _____

Address _____

Person Completing Exhibit _____

Title _____

Telephone Number _____

(a)

(b)

Earned

Incurred

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Line	Premium ³	Claims ⁴
1. Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues ⁵		
c. Net (for reporting purposes = 1a - 1b)		
2. Past Years' Experience (All Policy Years)		
3. Total Experience (Net Current Year + Past Year's Experience)		
4. Refunds Last Year (Excluding Interest) _____		
5. Previous Since Inception (Excluding Interest) _____		
6. Refunds Since Inception (Excluding Interest) _____		
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____		
8. Experienced Ratio Since Inception _____		
$\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}} = \text{Ratio 2}$		

9. Life Years Exposed Since Inception _____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than five hundred (500) life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table

Life Years Exposed

<u>Since Inception</u>	<u>Tolerance</u>
10,000 +	0.0%
5,000–9,999	5.0%
2,500–4,999	7.5%
1,000–2,499	10.0%
500–999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

12. Adjusted Incurred Claims _____

[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6).

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

¹ Individual, group, individual Medicare Select, or group Medicare Select only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan.

³ Includes Modal Loadings and Fees Charged.

⁴ Excluded Active Life Reserves.

⁵ This is to be used as "Issue Year Earned Premium" for Year 1 of the next year's "Worksheet for Calculation of Benchmark Ratios".

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name—Please Type

Title

Date

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____**

TYPE¹ _____

SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____

NAIC Company Code _____

Address _____

Person Completing Exhibit _____

Title _____

Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____**

TYPE¹ _____

SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____

NAIC Company Code _____

Address _____

Person Completing Exhibit _____

Title _____

Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Total:			(k):		(l):		(m):		(n):	
--------	--	--	------	--	------	--	------	--	------	--

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(Department of Insurance; 760 IAC 3-11-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 12. Filing and Approval of Policies and Certificates and Premium Rates

760 IAC 3-12-1 Filing and approval of policies and certificates and premium rates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner of the department of insurance in accordance with filing requirements and procedures prescribed by the commissioner of the department of insurance.

(b) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance.

(c) Except as provided in subsection (d), an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(d) An issuer may offer, with the approval of the commissioner of the department of insurance, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

- (1) The inclusion of new or innovative benefits.
- (2) The addition of either direct response or agent marketing methods.
- (3) The addition of either guaranteed issue or underwritten coverage.
- (4) The offering of coverage to individuals eligible for Medicare by reason of disability.

(e) As used in this section, "type" means:

- (1) an individual policy;
- (2) a group policy;
- (3) an individual Medicare select policy; or
- (4) a group Medicare select policy.

(f) Except as provided in subdivision (1), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this article that has been approved by the commissioner of the department of insurance. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months and as follows:

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner of the department of insurance in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner of the department of insurance, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form under subdivision (1) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as

the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the department of insurance of the discontinuance. The period of discontinuance may be reduced if the commissioner of the department of insurance determines that a shorter period is appropriate.

(g) For purposes of subsection (f), this subsection, and subsection (h), the sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance.

(h) A change in the rating structure or methodology shall be considered a discontinuance under subsection (f) unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner of the department of insurance, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner of the department of insurance may approve a change to the differential which is in the public interest.

(i) Except as provided in subsection (j), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 760 IAC 3-11.

(j) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (*Department of Insurance; 760 IAC 3-12-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2580; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 13. Permitted Compensation Arrangements

760 IAC 3-13-1 Permitted compensation arrangements

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(c) No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(d) No issuer or other entity shall provide to its agents or other producers, and no agent or producer shall receive:

(1) compensation for the sale of a Medicare supplement policy or certificate that differs from the compensation for the sale of any other Medicare supplement policy or certificate because of the level, type, or nature of benefits; or

(2) compensation for the sale of any Medicare supplement policy or certificate to a person that differs from the compensation that applies to the sale of any Medicare supplement policy or certificate to any other person because of the age, health status, claims experience, receipt of health care, or medical condition of that person.

(e) As used in this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including, but not limited to, the following:

(1) Bonuses.

(2) Gifts.

(3) Prizes.

(4) Awards.

(5) Finders fees.

(*Department of Insurance; 760 IAC 3-13-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1977; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 14. Required Disclosure Provisions

760 IAC 3-14-1 Required disclosure provisions

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12; IC 27-8-13-14; IC 27-8-13-15; IC 27-8-13-16
 Affected: IC 27-8-13-1

Sec. 1. (a) General provisions are as follows:

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned, appear on the first page of the policy, and include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare (Guide) in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request, but not later than at the time the policy is delivered.

As used in this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) Notice requirements are as follows:

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner of the department of insurance. Such notice shall do the following:

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(B) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) The outline of coverage requirements for Medicare supplement policies are as follows:

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”.

(3) The outline of coverage provided to applicants under this section consists of the following:

(A) The cover page described in subsection (e).

(B) Premium information on or immediately following the cover page.

(C) Disclosure pages described in subsection (f).

(D) Charts displaying the features of each benefit plan offered by the issuer described in subsection (g).

The outline of coverage shall be in the language and format prescribed in subsections (e) through (g) in no less than 12-point type. Plans A through J, described in 760 IAC 3-7, shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(d) The following are notices regarding policies or certificates that are not Medicare supplement policies:

(1) Any:

(A) accident and sickness insurance policy or certificate, other than a Medicare supplement policy;

(B) policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.);

(C) disability income policy; or

(D) other policy identified in 760 IAC 3-1-1(b);

issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”.

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision (1) shall disclose, using the applicable statement in this subdivision, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate. The following instructions and forms shall be used for the disclosure statement regarding duplication of Medicare:

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicates Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

2. All types of health insurance policies that duplicate Medicare shall include one (1) of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

6. Long term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not pre-empt state laws that are more stringent than the federal requirements.
8. The federal law does not pre-empt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended to allow for alternative disclosure statements. Carriers may use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE
DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE
DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE DUPLICATES
SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE
DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

with Medicare, available from the insurance company.

- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE
DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS INSURANCE
DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

with Medicare, available from the insurance company.

- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the previous statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS IS NOT MEDICARE
SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS IS NOT MEDICARE
SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS IS NOT MEDICARE
SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON
MEDICARE. THIS IS NOT MEDICARE
SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(e) The cover page of the outline described in subsection (c) shall be in the format as follows:

(COMPANY NAME)

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s) _____ (insert letter(s) of plan(s) being offered)

Medicare supplement insurance can be sold in only ten standard plans, plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan “A”. Some of the other plans may not be available from every company.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E	F / F*	G	H	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing
		Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
		At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Basic Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [\$1,500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plan J, the plan’s separate prescription drug deductible or, in Plans F and J, the plans’ separate foreign travel emergency deductible.

(f) The following items shall be included in the outline of coverage in the order prescribed:

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when the premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

The policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(g) The NAIC Model Laws, Regulations and Guidelines, Vol. IV, pages 651-40 through 651-67, Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (April 1998) are hereby incorporated by reference as if fully set out herein as the format for the charts described in subsection (c), except that on page 651-59, the Part B excess charges benefits for Plan "H" medical expenses is changed from eighty percent (80%) to zero (0) in the "Plan Pays" column. (*Department of Insurance; 760 IAC 3-14-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3431; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1978; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 15. Requirements for Application Forms and Replacement Coverage

760 IAC 3-15-1 Application forms and replacement coverage

Authority: IC 27-8-13-10; IC 27-8-13-16

Affected: IC 27-8-13-1

Sec. 1. (a) Application forms shall include statements and questions as established in this subsection designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing questions and statements may be used, such as the following:

(1) The following statements:

(A) You do not need more than one (1) Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple

coverages.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility.

(E) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(2) The following questions:

(A) To the best of your knowledge:

(i) Do you have another Medicare supplement policy or certificate in force?

(AA) If so, with which company?

(BB) If so, do you intend to replace your current Medicare supplement policy with this policy [certificate].

(ii) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(AA) If so, with which company?

(BB) What kind of policy?

(iii) Are you covered for medical assistance through the state Medicaid program:

(AA) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(BB) As a Qualified Medicare Beneficiary (QMB)?

(CC) For other Medicaid medical benefits?

(b) Agents shall list any other health insurance policies they have sold to the applicant. List policies sold:

(1) that are still in force; and

(2) in the past five (5) years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subsection (d) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplemental coverage. The replacement policy is being purchased for the following reasons (check one):

____ Additional benefits.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- _____ No change in benefits, but lower premiums.
 - _____ Fewer benefits and lower premiums.
 - _____ Other (please specify)_____
-
-

(1) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

(2) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

(f) Subsection (e)(1) and (e)(2) of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. (*Department of Insurance; 760 IAC 3-15-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2615; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3464; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 16. Filing Requirements for Advertising

760 IAC 3-16-1 Filing requirements for advertising

Authority: IC 27-8-13-10

Affected: IC 27-8-13-18

Sec. 1. An issuer shall file a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television media to the commissioner of the department of insurance of this state. (*Department of Insurance; 760 IAC 3-16-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 17. Standards for Marketing

760 IAC 3-17-1 Marketing

Authority: IC 27-8-13-10, IC 27-8-13-16

Affected: IC 27-4-1-4; IC 27-8-13-1

Sec. 1. (a) An issuer, directly or through its producers, shall do the following:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate is truly in the best interest of the applicant.

(4) Display prominently by type, stamp, or other appropriate means, on the first page of the policy, the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”.

(5) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(6) Establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited in IC 27-4-1-4, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(c) The terms "Medicare supplement", "Medigap", "Medicare wrap-around", and words of similar import shall not be used unless the policy is issued in compliance with this article. (*Department of Insurance; 760 IAC 3-17-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531*)

Rule 18. Recommended Purchase and Excessive Insurance

760 IAC 3-18-1 Appropriateness of recommended purchase and excessive insurance; reporting of multiple policies

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12

Affected: IC 27-8-13

Sec. 1. (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement coverage that will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited, except that an agent may sell a replacement policy or certificate in accordance with 760 IAC 3-1-15 [*sic.*] provided that the replacement policy or certificate is not made effective any sooner than is necessary to provide continuous benefits for preexisting conditions.

(c) An insurer which issues a Medicare supplement policy or certificate to any individual who has one (1) policy or certificate then in effect, except as permitted by subsection (b), shall, at the request of the insured, either refund the premiums or pay any claims on the policy or certificate, whichever is greater.

(d) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate:

(1) Policy and certificate number.

(2) Date of issuance.

(e) The items set forth in subsection (d) must be grouped by individual policyholder.

(f) The form for reporting the information required by subsection (d) is as follows:

FORM FOR REPORTING MEDICARE SUPPLEMENT MULTIPLE POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one (1) Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

(Department of Insurance; 760 IAC 3-18-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2617; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1987; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 19. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probation Periods

760 IAC 3-19-1 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods. *(Department of Insurance; 760 IAC 3-19-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 20. Separability

760 IAC 3-20-1 Separability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. If any provision of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 3-20-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

*